		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020131

Facility Name: Jacksonville Convalescent Center

Address: 1517 West Walnut (Number) Jacksonville (City) 62650 (Zip Code)

County: Morgan

Telephone Number: (217) 243-6451 **Fax #** (217) 243-8295

IDPA ID Number: 370983545001

Date of Initial License for Current Owners: 8/74

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jerry W. Jennings **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jerry W. Jennings

(Title) Controller

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,326	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,882	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,208	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	171		2,662	2,833	8
9	SNF/PED					9
10	ICF	15,021	8,485		23,506	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,192	8,485	2,662	26,339	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.78%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 2662

Medicare Intermediary AdminaStar Federal of Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	83,656	10,383	4,668	98,707		98,707	0	98,707			1
2	Food Purchase		85,904		85,904		85,904	(743)	85,161			2
3	Housekeeping	34,121	10,128		44,249		44,249	0	44,249			3
4	Laundry	20,373	8,212		28,585		28,585	0	28,585			4
5	Heat and Other Utilities			53,653	53,653		53,653	0	53,653			5
6	Maintenance	34,924	21,749	23,340	80,013		80,013	1,451	81,464			6
7	Other (specify):* Utility Workers	27,440			27,440		27,440	0	27,440			7
8	TOTAL General Services	200,514	136,376	81,661	418,551		418,551	708	419,259			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	551,169	66,512	36,294	653,975	(44,879)	609,096	401	609,497			10
10a	Therapy	10,881	941	87,699	99,521	(87,699)	11,822	0	11,822			10a
11	Activities	18,893	924		19,817		19,817	0	19,817			11
12	Social Services	11,480		3,178	14,658		14,658	0	14,658			12
13	Nurse Aide Training	7,228	138	8,422	15,788		15,788	0	15,788			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	599,651	68,515	147,593	815,759	(132,578)	683,181	401	683,582			16
	C. General Administration											
17	Administrative	53,183		9,829	63,012	1,237	64,249	34,129	98,378			17
18	Directors Fees							0				18
19	Professional Services			185,040	185,040		185,040	(177,471)	7,569			19
20	Dues, Fees, Subscriptions & Promotions			13,611	13,611		13,611	(3,040)	10,571			20
21	Clerical & General Office Expenses	16,292	5,471	4,508	26,271		26,271	16,483	42,754			21
22	Employee Benefits & Payroll Taxes			113,671	113,671		113,671	8,505	122,176			22
23	Inservice Training & Education			418	418		418	124	542			23
24	Travel and Seminar			2,359	2,359	(2,086)	273	867	1,140			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			54,955	54,955		54,955	251	55,206			26
27	Other (specify):*			15,876	15,876		15,876	(15,876)				27
28	TOTAL General Administration	69,475	5,471	400,267	475,213	(849)	474,364	(136,028)	338,336			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	869,640	210,362	629,521	1,709,523	(133,427)	1,576,096	(134,919)	1,441,177			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,738	11,738		11,738	23,463	35,201			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			22,149	22,149		22,149	0	22,149			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(128,452)	3,548			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			165,887	165,887		165,887	(104,989)	60,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					133,427	133,427	0	133,427			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			48,312	48,312		48,312	0	48,312			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			48,312	48,312	133,427	181,739		181,739			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	869,640	210,362	843,720	1,923,722	0	1,923,722	(239,908)	1,683,814			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,300	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(494)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,474)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(330)	20		17
18	Fines and Penalties	(154)	27		18
19	Entertainment				19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,157)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,899)	27		24
25	Fund Raising, Advertising and Promotional	(1,912)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,849)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,118)	20		28
29	Other-Attach Schedule VENDING	(743)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,330)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(230,402)	Various	34
35	Other- Attach Schedule **Sch. XIX-H Column 8**	824	6	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (229,578)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (239,908)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Therapy	X		87,699	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		1,057	10	42
43	Prescription Drugs **& Flu Shots**	X		39,199	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule **Oxygen**	X		2,876	10	45
46	Other-Attach Schedule **IV & Supplies**	X		2,596	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 133,427		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS **Page 5A**

Facility Name Jacksonville Convalescent Center

ID# 0020131

Report Period Beginning: 07/01/99

Ending: 06/30/00

Print Other Adjustments

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	0
9	Non-Straightline Depreciation	13,300	30	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	(494)	21	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(2,474)	27	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	(330)	20	Line 16	0
18	Fines and Penalties	(154)	27	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	(500)	27	Line 19	(3,157)
21	Owner or Key-Man Insurance	0	0	Line 20	(3,360)
22	Special Legal Fees & Legal Retainers	(3,157)	19	Line 21	(494)
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	(6,899)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(1,912)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	(5,849)	27	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	(1,118)	20	Line 27	(15,876)
29	Non-Paid Workers	0	0	Line 28	(22,887)
30	Donated Goods	0	0	Line 29	(22,887)
31	Amortization Expense	0	0	Line 30	13,300
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	13,300
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(9,587)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	390	0	0	0	0	0	0	0	0	0	390	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,157)	(174,500)	0	0	0	0	0	0	0	0	0	(177,657)	19
20	Fees, Subscriptions & Promotions	(3,360)	150	0	0	0	0	0	0	0	0	0	(3,210)	20
21	Clerical & General Office Expenses	(494)	122	0	0	0	0	0	0	0	0	0	(372)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(390)	0	0	0	0	0	0	0	0	0	(390)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,876)	0	0	0	0	0	0	0	0	0	0	(15,876)	27
28	**TOTAL General Administration**	(22,887)	(174,228)	0	0	0	0	0	0	0	0	0	(197,115)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,887)	(174,228)	0	0	0	0	0	0	0	0	0	(197,115)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	13,300	8,599	0	0	0	0	0	0	0	0	0	21,899	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,300	(123,401)	0	0	0	0	0	0	0	0	0	(110,101)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,587)	(297,629)	0	0	0	0	0	0	0	0	0	(307,216)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Jacksonville Convalescent Center # 0920131 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
R. Raymond Klein	25%	Of AdCon Convalescent Center	Godfrey	Nursing Home Mngrs.	Springfield	Management
Sam Klein	25%	Hilltop Nursing Home	Charleston	Frillo Land Trust	Springfield	Land Trust
Doris Berg, Trustee	50%	Meadow Manor	Taylorville			
		Menard Convalescent Center	Petersburg			
		Interim Manor of Virden	Virden			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	20 Rent	$ 132,000	Jacksonville Convalescent Center Land Trust	100.00%		$ (132,000)	1	-132000
2	V	20 Depreciation		Jacksonville Convalescent Center Land Trust	100.00%	8,599	8,599	2	8599
3	V	20 Trust Fees		Jacksonville Convalescent Center Land Trust	100.00%	150	150	3	150
4	V	21 Office Expense		Jacksonville Convalescent Center Land Trust	100.00%	122	122	4	122
5	V							5	
6	V							6	
7	V	19 Management Fee	181,685	Nursing Home Managers, Inc.	50.00%		(181,685)	7	-181685
8	V	Var. See Attached Schedule		Nursing Home Managers, Inc.	50.00%	67,227	67,227	8	67227
9	V	19 Accounting		Nursing Home Managers, Inc. - Direct Allocation	50.00%	7,185	7,185	9	7185
10	V	21 Travel	390	To transfer 101% of home office travel	50.00%		(390)	10	-390
11	V	19 Administrative Travel		to Administrative - per desk review	50.00%	390	390	11	390
12	V							12	
13	V							13	
14	Total		$ 314,675			$ 83,673	$ * (230,602)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	38	39	40	41	42	43

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Klein	President	Management	25%					$ 1,770	17-7	1
2	H. Raymond Klein	Owner		25%					1,770	17-7	2
3											3
4											4
5											5
6		Sam Klein and H. Raymond Klein were paid by Nursing Home Mangers, Inc.,									6
7		a related organization. Total compensation of $10,010 for each was allocated									7
8		among the six related nursing homes. based upon 10 hours per week for Sam Klein									8
9		and 10 hours per week for H. Raymond Klein.									9
10											10
11											11
12											12
13								TOTAL	$ 3,540		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nursing Home Managers, Inc.
Street Address: 2653 West Lawrence - Suite B
City / State / Zip Code: Springfield, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 46,569	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1998	$ 31,046	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,523)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,672	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ____ For 19 ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 22,149	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	30,012	8
	1996	30,537	9
	1997	31,641	10
	1998	31,046	11
	1999	25,115	12

Line 4: 1999 Tax Bill $ 25,115
6/12 of $25,115 12,557
$ 37,672

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1974	$ 35,003	1
2	Title Work		1989	426	2
3	TOTALS			$ 35,429	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	$ 541,766	$ 6,612	30	$ 17,295	$ 10,683	$ 541,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1975	3,850		5			3,850	9
10	Air Conditioning/Heating			1974	14,470		8			14,470	10
11	Motors			1980	533		5			533	11
12	Bids			1981	739	22	30	25	3	483	12
13	Furnace			1981	678		8			678	13
14	Fan			1981	972		15			972	14
15	Used Air Conditioner			1982	2,000		8			2,000	15
16	Vacuum Repair (Per 1982 Audit)			1982	1,031		10			1,031	16
17	Flooring			1983	1,229		10			1,229	17
18	Water Heater			1983	1,498		8			1,498	18
19	Water Heater			1983	1,575		8			1,575	19
20	Ceiling and Doors			1984	2,041	10	15	69	59	2,041	20
21	Asphalt			1984	13,350		15	445	445	13,350	21
22	Air Conditioner			1987	1,155		8			1,155	22
23	Sidewalks			1987	6,700	213	20	335	122	4,188	23
24	Roof			1988	21,783	692	20	1,088	396	12,523	24
25	Light Diffuser			1990	1,054	33	10	55	22	1,054	25
26	Flooring			1990	1,030	33	15	68	35	654	26
27	Water Heater			1992	1,450	46	15	96	50	823	27
28	Air Conditioner			1992	1,025	23	10	103	80	770	28
29	Rewire Fixtures			1992	1,110	35	10	111	76	833	29
30	Compressor			1993	1,479	33	10	147	114	961	30
31	Door Stops			1993	2,168	49	15	145	96	937	31
32	Roof			1993	34,178	772	20	1,708	936	11,107	32
33	Fire Doors			1996	1,011	26	15	67	41	302	33
34	Water Heaters			1997	3,915	100	15	261	161	838	34
35	Air Conditioner			1997	5,982	153	10	598	445	1,794	35
36	TOTAL (lines 4 thru 35)				$ 669772	$ 8,852		$ 22,616	$ 13,764	$ 623,415	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Swamp Cooler			1998	1,125	29	8	141	112	305	9
10	Water Heater			1998	1,950	50	15	130	80	227	10
11	Door Entrance			1999	2,672	49	15	134	85	134	11
12	Shutters			1999	912	15	15	40	25	40	12
13	Door Entrance			2000	4,507	14	15	50	36	50	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,166	$ 157		$ 495	$ 338	$ 756	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #NAME?	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 111,401	$ 10,207	$ 10,229	$ 22	Various	$ 52,163	37
38	Current Year Purchases	6,444	1,121	297	(824)	Various	297	38
39	Fully Depreciated Assets	119,882					119,882	39
40		(77,603)					(77,603)	40
41	TOTALS	$ 160,124	$ 11,328	$ 10,526	$ (802)		$ 94,739	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 876,491	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 20,337	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 33,637	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,300	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 718,910	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Jacksonville Convalescent Center Land Trust

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	88	8/1/74	$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		88		$ 132,000 **			7

10. Effective dates of current rental agreement:
Beginning 07/01/99
Ending 06/30/00

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/01	$ 132,000
13.	06/30/02	$ 132,000
14.	06/30/03	$ 132,000

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: Included in the above amount
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		138		138
3	Classroom Wages (a)	1,936	3,407		5,343
4	Clinical Wages (b)	31	1,854		1,885
5	In-House Trainer Wages (c)				
6	Transportation		1,099		1,099
7	Contractual Payments	1,942	4,931		6,873
8	Nurse Aide Competency Tests		450		450
9	TOTALS	$ 3,909	$ 11,879	$	$ 15,788
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,788			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	16

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-5	hrs	$	650	$ 28,803	$	650	$ 28,803	1
2	Licensed Speech and Language Development Therapist	39-5	hrs		193	3,783		193	3,783	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-5	hrs		1,288	55,113		1,288	55,113	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-5	# of prescrpts				39,199		39,199	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Supp,Lab,IV, Oxygen	39-5					6,529		6,529	13
14	TOTAL			$	2,130	$ 87,699	$ 45,728	2,130	$ 133,427	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 150,519	$ 156,017	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	291,695	291,695	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,952	16,952	6
7	Other Prepaid Expenses	55,436	55,436	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 514,602	$ 520,100	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	21,063	21,063	15
16	Equipment, at Historical Cost	143,622	235,786	16
17	Accumulated Depreciation (book methods)	(119,989)	(791,069)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 44,696	$ 160,053	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 559,298	$ 680,153	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 89,460	$ 89,460	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,612	37,612	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,393	7,393	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,672	37,672	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,849	5,849	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 177,986	$ 177,986	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 177,986	$ 177,986	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 381,312	$ 502,167	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 559,298	$ 680,153	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 552,593	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 552,592	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	382,339	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(436,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Jacksonville Land Trust Income**	123,236	15
16	Other (describe) **J'ville Land Trust Distributions to Owners**	(120,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (50,425)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 502,167	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,316,396	1
2	Discounts and Allowances for all Levels	(45,335)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,271,061	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,968	6
7	Oxygen	2,876	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 18,844	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,761	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	318	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,079	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,840	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending $743, Admit Fees $350, Wage Assign. $70	1,163	28
28a	Jury Duty $24, Miscellaneous $50	74	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,237	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,306,061	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 418,551	31
32	Health Care	815,759	32
33	General Administration	475,213	33
	B. Capital Expense		
34	Ownership	165,887	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	48,312	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,923,722	40
41	**Income before Income Taxes (line 30 minus line 40)****	382,339	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 382,339	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,488	1,616	$ 28,618	$ 17.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,073	6,231	92,219	14.80	3
4	Licensed Practical Nurses	11,831	12,301	124,541	10.12	4
5	Nurse Aides & Orderlies	37,639	38,716	305,791	7.90	5
6	Nurse Aide Trainees	1,403	1,403	7,228	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,378	1,404	10,881	7.75	8
9	Activity Director	1,822	1,873	11,435	6.11	9
10	Activity Assistants	1,351	1,373	7,458	5.43	10
11	Social Service Workers	1,852	1,882	11,480	6.10	11
12	Dietician					12
13	Food Service Supervisor	2,219	2,267	22,688	10.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,457	9,856	60,968	6.19	15
16	Dishwashers					16
17	Maintenance Workers	3,461	3,644	34,924	9.58	17
18	Housekeepers	5,515	5,741	34,121	5.94	18
19	Laundry	2,767	2,937	20,373	6.94	19
20	Administrator	2,000	2,080	53,183	25.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,185	2,218	16,292	7.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	5,216	5,269	27,440	5.21	33
34	TOTAL (lines 1 - 33)	97,655	100,808	$ 869,640 *	$ 8.63	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Preview

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 4,668	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	16	502	10-3	37
38	Nurse Consultant	708	21,998	10-3	38
39	Pharmacist Consultant	44	825	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	57	3,178	12-3	45
46	Other(specify)				46
47	Administrative Consultant	393	9,829	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,529	$ 53,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	216	5,233	10-3	51
52	Nurse Aides	444	7,736	10-3	52
53	TOTAL (lines 50 - 52)	660	$ 12,969		53

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anna Newingham	Administrator	0.00%	$ 53,183
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,183

B. Administrative - Other

Description	Amount
Administrative Consultant	$ 9,829
TOTAL (agree to Schedule V, line 17, col. 3)	$ 9,829
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nursing Home Managers, Inc.	Management	$ 181,685
Feldman,Wasser,Draper,Benson	Legal	2,404
Dudley & Smith	Legal	753
CSC	Corp. Representation	198
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 185,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,633
Unemployment Compensation Insurance	17,919
FICA Taxes	63,681
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Section 125 Plan	15,582
Employee Life Insurance	1,606
HBV Vaccine	1,050
Gift Certificates	750
Employee Christmas Party	450
Nursing Home Managers Allocation	8,505
TOTAL (agree to Schedule V, line 22, col.8)	$ 122,176

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV Vaccine	22	$ 1,050
Gift Certificates	22	750
Employee Christman Party	22	450
TOTAL		$ 2,250

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,167
Health Care Worker Background Check	984
(Indicate # of checks performed 82)	
See Attached Schedule	3,460
J'ville Land Trust - Trust Fees	150
Nursing Home Managers Allocation	170
Less: Non-allowable Dues & Fees	(330)
Less: Public Relations Expense	(1,912)
Non-allowable advertising	( )
Yellow page advertising	(1,118)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Miscellaneous Mileage Reimbursement	273
Nursing Home Managers Allocation	867
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,140

**See instructions.

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Paint	7/90-6/91	$ 1,384	3 Yrs	$	$	$	$	$	$	$	$	$
2	Interior Paint	7/92-6/93	1,970	3 Yrs									
3	Wallpaper & Paint	7/93-6/94	6,214	3 Yrs	1,036								
4	Wallpaper & Paint	7/94-6/95	3,051	3 Yrs	1,017	508							
5	Wallpaper & Paint	7/96-6/97	4,944	3 Yrs	824	1,648	1,648	824					
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,563		$ 2,877	$ 2,156	$ 1,648	$ 824	$	$	$	$	$

Print Preview

Facility Name & ID Number Jacksonville Convalescent Center # 0020131 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 9 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ $ 0 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ $ 48,312
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Line 27 General Administration - Other

Sales Tax	$	2474
Bad Debts		6899
Contributions		500
Illinois RT Tax		5849
Penalty		154
Total Line 27 Column 3	$	15876

Detail Column 5 - Reclassifications

			Line #
Reclass To:			
Nurse Consultant Travel	$	849	10
Administrative Consultant Travel		1237	17
Reclass From: Travel	$	-2086	24

Reclass From:			
Medicare Drugs	$	-38881	10
Medicare Supplies		-153	10
Medicare Laboratory Fees		-1057	10
Medicare I.V. Therapy		-2443	10
Oxygen		-2876	10
Flu Shots		-318	10
Physical Therapy		-55113	10a
Speech Therapy		-3783	10a
Occupational Therapy		-28803	10a
Reclass To:			
Ancillary Services	$	133427	39

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Page 13 - Schedule XI - Section E

Reconciliation of Depreciation

Line 49 - Straight Line Depreciation	$	33637
Nursing Home Managers Allocation		1564
Schedule V - Line 30 - Column 8	$	35201

Page 15 - Schedule XII

Trained at: Sunrise Manor of Virden, Inc.
333 S. Wrightsman
Virden, IL 62690

Cost Per Aide Trained: 9 @ $547.89

Page 19 - Schedule XVII

Reconciliation of Income

Net Income - Line 43	$	382339
* Management Fee 6/30/99		-14360
* Management Fee 6/30/00		16717
Interest Income passed directly to Stockholders		-11840
Contributions		500
Penalty		154
Taxable Income	$	373510

* Related party accounts payable not allowed for tax purposes included here for consistancy with prior year Cost Reports and to conform with accrual accounting me

Page 21 - Schedule XIX - Section F
Dues, Fees, Subscriptions, and Promotions

Yellow Pages	$	1118
Public Relations		1912
Chamber of Commerce Dues		180
Franchise Fees		100
HCFA Lab Fees		150
	$	3460

Page 23 - Schedule XX
Question # 12

Salary costs allocated to department worked based upon time cards.

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ethods.

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SCHEDULE VII - PAGE 6, LINE 8

CENTRAL OFFICE COST ALLOCATION
JACKSONVILLE
1999

	JULY 99	AUG	SEPT	OCT	NOV	DEC	JAN 00	FEB	MARCH	APRIL	MAY	JUNE	1999 TOTAL	Line #
SALARIES-ADMIN	$2,346	$2,481	$2,499	$2,443	$2,414	$2,465	$2,461	$2,576	$2,643	$2,706	$2,581	$2,583	$30,199	17
SALARIES-CLERIC	1,041	1,227	1,237	1,209	1,194	1,220	1,262	1,321	1,356	1,388	1,324	1,325	15,104	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	0	81	81	80	79	80	0	0	0	0	0	0	401	10
ACCOUNTING	19	23	24	23	23	23	8	8	9	9	8	8	186	19
WORK COMP INS	6	4	4	4	4	4	13	14	14	14	14	14	110	22
SUPPLIES	82	55	55	54	54	55	120	125	129	132	126	126	1,112	21
TELEPHONE	44	47	48	47	46	47	57	60	61	63	60	60	639	21
EMPL BENEFITS	372	378	381	373	368	376	407	426	437	447	426	427	4,818	22
PAYROLL TAXES	242	287	289	282	279	285	303	317	325	333	317	318	3,577	22
TRAVEL	15	29	29	29	28	29	174	182	187	191	182	182	1,257	24
IN SERVICE	26	5	5	5	4	5	12	12	13	13	12	12	124	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	13	3	3	3	3	3	19	20	20	21	20	20	146	6
OWNERS COMP	289	288	290	283	280	286	289	302	310	317	303	303	3,540	17
INS-PROP,LIAB,WC	20	20	20	20	19	20	21	22	22	23	22	22	251	26
DEPRECIATION	119	121	122	119	118	120	134	140	144	147	141	141	1,564	30
RENT	291	279	281	275	271	277	297	311	319	326	311	311	3,548	34
MAINTENANCE	13	64	64	63	62	63	24	25	26	26	25	25	481	6
FEES & PUBLICAT	4	25	25	24	24	25	4	5	5	5	5	5	155	20
ADVERTISING	0	0	0	0	0	0	2	2	3	3	2	2	15	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$4,942	$5,417	$5,457	$5,334	$5,271	$5,383	$5,606	$5,867	$6,022	$6,165	$5,879	$5,884	$67,227	
FIXED ASSETS														
EQUIP - PRIOR	9,484	9,194	9,262	9,054	8,947	9,135	8,033	8,407	8,628	8,834	8,423	8,431	8,819	
EQUIP - CURR	553	1,178	1,187	1,160	1,146	1,170	1,625	2,065	3,972	4,067	3,878	3,882	2,157	
EQUIP - FULLY DEP	983	953	960	939	928	947	982	1,028	1,055	1,080	1,030	1,031	993	
BLDG - PRIOR	1,178	1,142	1,151	1,125	1,111	1,135	1,177	1,231	1,264	1,294	1,234	1,235	1,190	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

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MONTHLY CENTRAL OFFICE COST ALLOCATIONS

COST ALLOCATION
JULY 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.24%	14.95%	17.52%	19.52%	11.20%	18.57%	100.00%
SALARIES-ADMIN	$2,442	$2,002	$2,346	$2,614	$1,500	$2,486	$13,390
SALARIES-CLERIC	1,083	888	1,041	1,160	666	1,103	5,940
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	20	17	19	22	12	21	111
WORK COMP INS	6	5	6	7	4	6	34
SUPPLIES	85	70	82	91	52	87	468
TELEPHONE	46	38	44	49	28	47	251
EMPL BENEFITS	387	318	372	415	238	394	2,124
PAYROLL TAXES	252	207	242	270	155	257	1,383
TRAVEL	16	13	15	17	10	16	88
IN SERVICE	27	22	26	29	17	28	149
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	11	13	14	8	13	71
OWNERS COMP	301	247	289	322	185	306	1,650
INS-PROP,LIAB,WC	21	17	20	22	13	21	113
DEPRECIATION	123	101	119	132	76	126	677
RENT	303	248	291	324	186	308	1,660
MAINTENANCE	14	11	13	15	8	14	76
FEES & PUBLIC	5	4	4	5	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,145	$4,218	$4,942	$5,507	$3,161	$5,238	$28,210
FIXED ASSETS							
EQUIP - PRIOR	9,874	8,095	9,484	10,568	6,066	10,051	54,137
EQUIP - CURR	576	472	553	617	354	587	3,159
EQUIP - FULLY DEP	1,024	839	983	1,096	629	1,042	5,614
BLDG - PRIOR	1,227	1,006	1,178	1,313	753	1,249	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.57%	14.57%	16.98%	19.49%	11.65%	18.74%	100.00%
SALARIES-ADMIN	$2,713	$2,128	$2,481	$2,847	$1,702	$2,738	$14,609
SALARIES-CLERIC	1,342	1,053	1,227	1,408	842	1,354	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	88	69	81	93	55	89	476
ACCOUNTING	26	20	23	27	16	26	138
WORK COMP INS	5	4	4	5	3	5	25
SUPPLIES	60	47	55	63	38	61	324
TELEPHONE	52	41	47	54	33	52	279
EMPL BENEFITS	414	325	378	434	260	418	2,229
PAYROLL TAXES	314	246	287	329	197	316	1,689
TRAVEL	32	25	29	33	20	32	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	3	2	3	18
OWNERS COMP	315	247	288	330	197	317	1,694
INS-PROP,LIAB,WC	22	17	20	23	14	22	118
DEPRECIATION	132	104	121	139	83	133	711
RENT	305	239	279	320	191	308	1,642
MAINTENANCE	70	55	64	73	44	70	375
FEES & PUBLIC	27	21	25	28	17	27	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,925	$4,646	$5,417	$6,215	$3,716	$5,978	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,056	7,886	9,194	10,549	6,308	10,146	54,137
EQUIP - CURR	1,288	1,010	1,178	1,351	808	1,300	6,936
EQUIP - FULLY DEP	1,043	818	953	1,094	654	1,052	5,614
BLDG - PRIOR	1,249	980	1,142	1,310	784	1,260	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.68%	14.55%	17.11%	19.74%	12.69%	17.24%	100.00%
SALARIES-ADMIN	$2,728	$2,125	$2,499	$2,884	$1,853	$2,518	$14,609
SALARIES-CLERIC	1,350	1,051	1,237	1,427	917	1,246	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	89	69	81	94	60	82	476
ACCOUNTING	26	20	24	27	18	24	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	61	47	55	64	41	56	324
TELEPHONE	52	41	48	55	35	48	279
EMPL BENEFITS	416	324	381	440	283	384	2,229
PAYROLL TAXES	315	246	289	333	214	291	1,689
TRAVEL	32	25	29	34	22	29	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	3	2	3	18
OWNERS COMP	316	246	290	334	215	292	1,694
INS-PROP,LIAB,WC	22	17	20	23	15	20	118
DEPRECIATION	133	103	122	140	90	123	711
RENT	307	239	281	324	208	283	1,642
MAINTENANCE	70	55	64	74	48	65	375
FEES & PUBLIC	27	21	25	29	19	25	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,957	$4,640	$5,457	$6,297	$4,047	$5,498	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,111	7,876	9,262	10,687	6,868	9,332	54,137
EQUIP - CURR	1,295	1,009	1,187	1,369	880	1,196	6,936
EQUIP - FULLY DEP	1,049	817	960	1,108	712	968	5,614
BLDG - PRIOR	1,256	978	1,151	1,328	853	1,159	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.07%	14.47%	16.72%	20.30%	13.21%	16.22%	100.00%
SALARIES-ADMIN	$2,786	$2,115	$2,443	$2,965	$1,930	$2,370	$14,609
SALARIES-CLERIC	1,378	1,046	1,209	1,467	955	1,172	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	69	80	97	63	77	476
ACCOUNTING	26	20	23	28	18	22	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	54	66	43	53	324
TELEPHONE	53	40	47	57	37	45	279
EMPL BENEFITS	425	323	373	452	295	362	2,229
PAYROLL TAXES	322	244	282	343	223	274	1,689
TRAVEL	33	25	29	35	23	28	171
IN SERVICE	5	4	5	5	4	4	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	323	245	283	344	224	275	1,694
INS-PROP,LIAB,WC	22	17	20	24	16	19	118
DEPRECIATION	136	103	119	144	94	115	711
RENT	313	238	275	333	217	266	1,642
MAINTENANCE	72	54	63	76	50	61	375
FEES & PUBLIC	28	21	24	30	19	24	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,082	$4,617	$5,334	$6,474	$4,215	$5,174	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,323	7,836	9,054	10,988	7,154	8,782	54,137
EQUIP - CURR	1,323	1,004	1,160	1,408	917	1,125	6,936
EQUIP - FULLY DEP	1,071	813	939	1,139	742	911	5,614
BLDG - PRIOR	1,282	973	1,125	1,365	889	1,091	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.10%	14.64%	16.53%	20.81%	12.45%	16.48%	100.00%
SALARIES-ADMIN	$2,790	$2,138	$2,414	$3,040	$1,819	$2,407	$14,609
SALARIES-CLERIC	1,380	1,058	1,194	1,504	900	1,191	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	70	79	99	59	78	476
ACCOUNTING	26	20	23	29	17	23	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	54	67	40	53	324
TELEPHONE	53	41	46	58	35	46	279
EMPL BENEFITS	426	326	368	464	278	367	2,229
PAYROLL TAXES	323	247	279	351	210	278	1,689
TRAVEL	33	25	28	36	21	28	171
IN SERVICE	5	4	4	6	3	4	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	324	248	280	352	211	279	1,694
INS-PROP,LIAB,WC	22	17	19	25	15	19	118
DEPRECIATION	136	104	118	148	89	117	711
RENT	314	240	271	342	204	271	1,642
MAINTENANCE	72	55	62	78	47	62	375
FEES & PUBLIC	28	21	24	30	18	24	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,092	$4,669	$5,271	$6,637	$3,972	$5,256	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,340	7,925	8,947	11,264	6,741	8,920	54,137
EQUIP - CURR	1,325	1,015	1,146	1,443	864	1,143	6,936
EQUIP - FULLY DEP	1,072	822	928	1,168	699	925	5,614
BLDG - PRIOR	1,284	984	1,111	1,399	837	1,108	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.08%	14.49%	16.87%	20.33%	12.26%	16.97%	100.00%
SALARIES-ADMIN	$2,787	$2,117	$2,465	$2,969	$1,791	$2,479	$14,609
SALARIES-CLERIC	1,379	1,047	1,220	1,469	886	1,226	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	69	80	97	58	81	476
ACCOUNTING	26	20	23	28	17	23	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	55	66	40	55	324
TELEPHONE	53	40	47	57	34	47	279
EMPL BENEFITS	425	323	376	453	273	378	2,229
PAYROLL TAXES	322	245	285	343	207	287	1,689
TRAVEL	33	25	29	35	21	29	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	323	245	286	344	208	287	1,694
INS-PROP,LIAB,WC	22	17	20	24	14	20	118
DEPRECIATION	136	103	120	145	87	121	711
RENT	313	238	277	334	201	279	1,642
MAINTENANCE	72	54	63	76	46	64	375
FEES & PUBLIC	28	21	25	30	18	25	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,086	$4,622	$5,383	$6,484	$3,911	$5,413	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,329	7,844	9,135	11,004	6,638	9,187	54,137
EQUIP - CURR	1,323	1,005	1,170	1,410	850	1,177	6,936
EQUIP - FULLY DEP	1,071	813	947	1,141	688	953	5,614
BLDG - PRIOR	1,283	974	1,135	1,367	825	1,141	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
SALARIES-ADMIN	$2,762	$2,058	$2,461	$2,856	$1,668	$2,261	$14,066
SALARIES-CLERIC	1,417	1,056	1,262	1,465	856	1,160	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	5	7	$46
WORK COMP INS	15	11	13	15	9	12	$75
SUPPLIES	134	100	120	139	81	110	$685
TELEPHONE	64	48	57	66	39	52	$326
EMPL BENEFITS	456	340	407	472	276	374	$2,324
PAYROLL TAXES	340	253	303	351	205	278	$1,730
TRAVEL	195	145	174	202	118	160	$993
IN SERVICE	13	10	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	21	16	19	22	13	17	$108
OWNERS COMP	324	241	289	335	196	265	$1,650
INS-PROP,LIAB,WC	24	18	21	24	14	19	$120
DEPRECIATION	150	112	134	156	91	123	$766
RENT	333	248	297	344	201	273	$1,696
MAINTENANCE	27	20	24	28	16	22	$137
FEES & PUBLIC	5	4	4	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,291	$4,688	$5,606	$6,507	$3,801	$5,150	$32,044
FIXED ASSETS							
EQUIP - PRIOR	9,014	6,717	8,033	9,323	5,446	7,379	45,912
EQUIP - CURR	1,824	1,359	1,625	1,886	1,102	1,493	9,290
EQUIP - FULLY DEP	1,102	821	982	1,140	666	902	5,614
BLDG - PRIOR	1,320	984	1,177	1,366	798	1,081	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
SALARIES-ADMIN	$2,620	$2,003	$2,576	$2,784	$1,713	$2,371	$14,066
SALARIES-CLERIC	1,344	1,028	1,321	1,428	879	1,216	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	6	8	$46
WORK COMP INS	14	11	14	15	9	13	$75
SUPPLIES	128	98	125	136	83	115	$685
TELEPHONE	61	46	60	65	40	55	$326
EMPL BENEFITS	433	331	426	460	283	392	$2,324
PAYROLL TAXES	322	246	317	342	211	292	$1,730
TRAVEL	185	141	182	196	121	167	$993
IN SERVICE	13	10	12	13	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	18	$108
OWNERS COMP	307	235	302	327	201	278	$1,650
INS-PROP,LIAB,WC	22	17	22	24	15	20	$120
DEPRECIATION	143	109	140	152	93	129	$766
RENT	316	241	311	336	207	286	$1,696
MAINTENANCE	26	20	25	27	17	23	$137
FEES & PUBLIC	5	4	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,968	$4,563	$5,867	$6,341	$3,903	$5,402	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,550	6,538	8,407	9,085	5,592	7,740	45,912
EQUIP - CURR	2,100	1,606	2,065	2,231	1,373	1,901	11,276
EQUIP - FULLY DEP	1,046	799	1,028	1,111	684	946	5,614
BLDG - PRIOR	1,252	958	1,231	1,331	819	1,134	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
SALARIES-ADMIN	$2,588	$1,926	$2,643	$2,724	$1,704	$2,482	$14,066
SALARIES-CLERIC	1,328	988	1,356	1,397	874	1,273	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	126	94	129	133	83	121	$685
TELEPHONE	60	45	61	63	39	58	$326
EMPL BENEFITS	428	318	437	450	282	410	$2,324
PAYROLL TAXES	318	237	325	335	210	305	$1,730
TRAVEL	183	136	187	192	120	175	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	19	$108
OWNERS COMP	304	226	310	320	200	291	$1,650
INS-PROP,LIAB,WC	22	16	22	23	15	21	$120
DEPRECIATION	141	105	144	148	93	135	$766
RENT	312	232	319	328	205	299	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,896	$4,386	$6,022	$6,205	$3,882	$5,653	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,447	6,285	8,628	8,890	5,562	8,100	45,912
EQUIP - CURR	3,889	2,894	3,972	4,093	2,561	3,729	21,138
EQUIP - FULLY DEP	1,033	769	1,055	1,087	680	990	5,614
BLDG - PRIOR	1,237	921	1,264	1,302	815	1,186	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
SALARIES-ADMIN	$2,577	$1,895	$2,706	$2,748	$1,696	$2,443	$14,066
SALARIES-CLERIC	1,322	972	1,388	1,410	870	1,253	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	125	92	132	134	83	119	$685
TELEPHONE	60	44	63	64	39	57	$326
EMPL BENEFITS	426	313	447	454	280	404	$2,324
PAYROLL TAXES	317	233	333	338	209	300	$1,730
TRAVEL	182	134	191	194	120	172	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	21	21	13	19	$108
OWNERS COMP	302	222	317	322	199	287	$1,650
INS-PROP,LIAB,WC	22	16	23	23	14	21	$120
DEPRECIATION	140	103	147	150	92	133	$766
RENT	311	228	326	331	204	295	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,871	$4,316	$6,165	$6,261	$3,864	$5,566	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,412	6,184	8,834	8,971	5,536	7,975	45,912
EQUIP - CURR	3,873	2,847	4,067	4,130	2,549	3,672	21,138
EQUIP - FULLY DEP	1,029	756	1,080	1,097	677	975	5,614
BLDG - PRIOR	1,232	906	1,294	1,314	811	1,168	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
SALARIES-ADMIN	$2,637	$1,938	$2,581	$2,876	$1,659	$2,376	$14,066
SALARIES-CLERIC	1,353	994	1,324	1,475	851	1,219	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	6	8	9	5	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	128	94	126	140	81	116	$685
TELEPHONE	61	45	60	67	38	55	$326
EMPL BENEFITS	436	320	426	475	274	393	$2,324
PAYROLL TAXES	324	238	317	354	204	292	$1,730
TRAVEL	186	137	182	203	117	168	$993
IN SERVICE	13	9	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	22	13	18	$108
OWNERS COMP	309	227	303	337	195	279	$1,650
INS-PROP,LIAB,WC	22	16	22	24	14	20	$120
DEPRECIATION	144	106	141	157	90	129	$766
RENT	318	234	311	347	200	286	$1,696
MAINTENANCE	26	19	25	28	16	23	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,007	$4,414	$5,879	$6,552	$3,780	$5,412	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,606	6,325	8,423	9,388	5,416	7,754	45,912
EQUIP - CURR	3,962	2,912	3,878	4,322	2,494	3,570	21,138
EQUIP - FULLY DEP	1,052	773	1,030	1,148	662	948	5,614
BLDG - PRIOR	1,261	926	1,234	1,375	793	1,136	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
SALARIES-ADMIN	$2,626	$2,055	$2,583	$2,846	$1,694	$2,264	$14,066
SALARIES-CLERIC	1,347	1,054	1,325	1,460	869	1,161	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	8	9	6	7	46
WORK COMP INS	14	11	14	15	9	12	75
SUPPLIES	128	100	126	139	82	110	685
TELEPHONE	61	48	60	66	39	52	326
EMPL BENEFITS	434	339	427	470	280	374	2,324
PAYROLL TAXES	323	253	318	350	208	278	1,730
TRAVEL	185	145	182	201	120	160	993
IN SERVICE	13	10	12	14	8	11	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	20	22	13	17	108
OWNERS COMP	308	241	303	334	199	266	1,650
INS-PROP,LIAB,WC	22	17	22	24	14	19	120
DEPRECIATION	143	112	141	155	92	123	766
RENT	317	248	311	343	204	273	1,696
MAINTENANCE	26	20	25	28	17	22	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	2	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,982	$4,680	$5,884	$6,482	$3,858	$5,157	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,571	6,706	8,431	9,288	5,528	7,388	45,912
EQUIP - CURR	3,946	3,088	3,882	4,276	2,545	3,402	21,138
EQUIP - FULLY DEP	1,048	820	1,031	1,136	676	903	5,614
BLDG - PRIOR	1,255	982	1,235	1,360	810	1,082	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0